ATTACHMENT 2 Sample CMS 1500 claim form for Community Care Organizations

PICA		HEALTH INS	SURANC	E CLA	IM FO	ORM		PICA
I. MEDICARE MEDICAID CHAMPUS CHA		CA OTHER	1a. INSURED'	S I.D. NUME	BER	**	(FOR P	ROGRAM IN ITEM 1)
(Medicare #) P (Medicaid #) (Sponsor's SSN) (VA	File #) (SSN or ID)	(SSN) (ID)			1	L234	567	890
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S	NAME (Las				
Recipient, Im A.	MM DD YY M		l	•	-		_	•
D. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP 1		7. INSURED'S	ADDRESS	(No. Stree	at)		
609 Willow St	Self Spouse Chil	d Other			(. 10., 00	,		
	TATE 8. PATIENT STATUS	<u> </u>	CITY					
	- - !		0					STATE
	NI Single Married	Other						
P CODE TELEPHONE (Include Area Code)	Employed - Full-Time -	Part-Time	ZIP CODE		TE	LEPHO	NE (INCI	LUDE AREA CODE)
55555 (XXX) XXX-XXXX	Student	Student				()	
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITIO	N RELATED TO:	11. INSURED'S	S POLICY G	ROUP OR	FECA N	UMBER	
OI-D								
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURREN	TOR PREVIOUS)	a. INSURED'S	DATE OF B	IRTH			SEX
	YES	NO	MIM	DD	* *	N	4	F
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER	'S NAME O	R SCHOOL	L NAME		
MM DD YY	YE\$	□NO						
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?		C INSTIDANCE	E DI AN NAS	AE OP PO	OCDAN	NAME	
	YES	□NO	C. INSURANCE PLAN NAME OR PROGRAM NAME					
INSURANCE PLAN NAME OR PROGRAM NAME		_1						
NOODANGE FLAN NAME ON FRUGHAM NAME	10d. RESERVED FOR LOCAL	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
								omplete item 9 a-d.
READ BACK OF FORM BEFORE COMPLI PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize		formation necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize					
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignmen below.			payment of medical benefits to the undersigned physician or supplier for services described below.					
below.								
SIGNED	DATE		SIGNED					
DATE OF CURRENT: ILLNESS (First symptom) OR	15. IF PATIENT HAS HAD SAME OF	R SIMILAR ILLNESS.	16. DATES PA	TIENT UNA	BLE TO W	ORK IN	CURRE	T OCCUPATION
MM DD YY INJURY (Accident) OR PREGNANCY(LMP)	GIVE FIRST DATE MM DI	P YY	FROM	DD	W	т	MM C	DD YY
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING	PHYSICIAN	18. HOSPITAL	IZATION DA	TES RELA	ATED TO	CURRE	NT SERVICES
			FROM	DD	YY	т	MM	DD YY
RESERVED FOR LOCAL USE			20. OUTSIDE L	AB?			ARGES	<u> </u>
				_	1	Ψ Οι 17	"I'ULU	1
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT	EMS 1 2 2 OB 4 TO ITEM 24E BY I IN	E\	YES 22. MEDICAID	NO NO	01011			J
	EMS 1,2,3 ON 4 10 11EM 24E BT LIN	5) —	CODE	RESUBMIS	OR	IGINAL F	REF. NO	
<u> </u>	3	,						***
			23. PRIOR AUT	THORIZATIO	ON NUMBE	≣R		
. <u></u>	4,	_						
DATE(S) OF SERVICE Place Type PROC	D EDURES, SERVICES, OR SUPPLIES	E	F		3 H	1	-	K
From ' To of of of	Explain Unusual Circumstances)	DIAGNOSIS CODE	\$ CHARGE	- lo	R Famil	y EMG	СОВ	RESERVED FOR LOCAL USE
IM DD YY MM DD YY Service Service CPT	HCPCS MODIFIER			UN	ITS Plan	+	-	200/12 002
01 01 04 01 31 04 99 1 G	9002	1	XXX	XX 3	1			
								-
			į į]	1		
					_	1		
			;	1				
			 		+	+	\vdash	
	ı l					1		
	L				+	-	\vdash	
	<u> </u>			- 1				
						↓	L	
	1 1					1]	
	1 ; 308					<u>L</u>		
		OT ACCICNIMENTS	28. TOTAL CHA	ARGE	29. AMC	OUNT PA	ND D	30. BALANCE DUE
	T'S ACCOUNT NO. 27. ACCEI	t. claims, see back)					1 1	s XXX X
	T'S ACCOUNT NO. 27. ACCEI (For gov	A. Ciaims, see back)	\$ X)	KX XX	\$	0	00	* /////
SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME A	4JED (For government) (For government) YES IND ADDRESS OF FACILITY WHERE	NO	33. PHYSICIAN	I'S, SUPPLIE	. 1			RESS, ZIP CODE
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 22. NAME RENDE	4JED (For gov	NO	33. PHYSICIAN & PHONE #	'S, SUPPLIE	. 1			
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	4JED (For government) (For government) YES IND ADDRESS OF FACILITY WHERE	NO	33. PHYSICIAN & PHONE #	is, supplie	ER'S BILLI			
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	4JED (For government) (For government) YES IND ADDRESS OF FACILITY WHERE	NO	33. PHYSICIAN & PHONE # I.M. Bil 1 W. W	rs, supplii lling lilliams	ER'S BILLI	NG NAM		
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	4JED (For government) (For government) YES IND ADDRESS OF FACILITY WHERE	NO	33. PHYSICIAN & PHONE #	rs, supplii lling lilliams	R'S BILLI	NG NAM		